

Personal Choice

Summary of Benefits



LEHB

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 expansive 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 ²	Calendar Year ²
DEDUCTIBLE		
Individual	\$0	\$500
Family	\$0	\$1,000
AFTER DEDUCTIBLE, PLAN PAYS	100% Unless otherwise noted	50%
OUT-OF-POCKET MAXIMUM⁵		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	\$15 Copayment	50%, after deductible
Specialist Services	\$25 Copayment	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	50%, NO deductible
PEDIATRIC IMMUNIZATIONS	100%	50%, NO deductible
ROUTINE GYNECOLOGICAL EXAM/PAP <i>1 per year for women of any age³</i>	100%	50%, NO deductible
MAMMOGRAM	100%	50%, 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.

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

Benefit	In-Network	Out-of-Network ¹
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT <i>6 visits per benefit period²</i>	100%	50%, after deductible
ALLERGY INJECTIONS <i>(Office visit copayment waived if no office visit is charged)</i>	100%	50%, after deductible
MATERNITY <i>All benefits for the newborn of a dependent daughter are excluded from coverage after the mother (dependent daughter) has been discharged from the hospital. If the newborn remains in the hospital after the mothers discharge the newborn will be assigned its own claim. This becomes a different and separate admission which would not be covered under the LEHB plan.</i>		
First OB visit	\$15 Copayment	50%, after deductible
Hospital	100%	50%, after deductible ³
INPATIENT HOSPITAL SERVICES		
Facility	100%	50%, after deductible ³
Physician/Surgeon	100%	50%, after deductible
INPATIENT HOSPITAL DAYS	365	70 ³
OUTPATIENT SURGERY		
Facility	100%	50%, after deductible
Physician/Surgeon	100%	50%, after deductible
EMERGENCY ROOM	\$25 Copayment (Copayment waived if admitted)	\$25 Copayment, NO deductible (Copayment waived if admitted)
URGENT CARE CENTER	\$17 Copayment	50%, after deductible
AMBULANCE		
Emergency	100%	100%, NO deductible
Non-emergency	100%	50%, after deductible
OUTPATIENT LABORATORY	100%	50%, after deductible
OUTPATIENT RADIOLOGY	100%	50%, after deductible
THERAPY SERVICES		
Physical, Speech and Occupational	\$10 Copayment	50%, after deductible
Cardiac Rehabilitation <i>36 visits per year²</i>	\$10 Copayment	50%, after deductible
Pulmonary Rehabilitation <i>12 visits per year²</i>	\$10 Copayment	50%, after deductible
Respiratory Therapy	\$10 Copayment	50%, after deductible
Orthoptic/Pleoptic Therapy <i>limited to 8 sessions lifetime maximum²</i>	\$10 Copayment	50%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE <i>(12 visits per year)²</i>	\$25 Copayment	50%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	50%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	100%	50%, after deductible
SKILLED NURSING FACILITY	100%	50%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	50%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	100%	50%, after 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

3 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
OUTPATIENT MENTAL HEALTH CARE	\$25 Copayment	50%, after deductible
INPATIENT MENTAL HEALTH CARE	100%	50%, after deductible
SERIOUS MENTAL ILLNESS CARE		
Outpatient	\$25 Copayment	50%, after deductible
Inpatient	100%	50%, after deductible ³
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits	\$25 Copayment	50%, after deductible
Rehabilitation	100%	50%, after deductible ³
Detoxification	100%	50%, after deductible ³

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.

3 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.

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
- Maintenance of chronic conditions
- Self-injectable drugs
- Immunizations required for employment or travel.
- Gender reassignment surgery

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.