

Personal Choice PPO 5000 HSA



Benefits per calendar year	You pay in-network	You pay out-of-network*
Deductible, individual/family	\$5,000/\$10,000	\$10,000/\$20,000
Coinsurance, after deductible	N/A	50%
Out-of-pocket maximum, individual/family (includes deductibles, copays, and coinsurance)	\$5,000/\$10,000	\$20,000/\$40,000

Preventive services

Mammogram	\$0, no deductible	50%, no deductible
Pediatric immunizations (subject to office visit copay)		
Nutrition counseling (6 visits per year ¹)		50%, after deductible

Physician services

Primary care office visit	\$0, after deductible	50%, after deductible
Specialist office visit		
Routine gynecological exam/Pap test (1 per year)	\$0, no deductible	50%, no deductible
Routine eye care	Not covered	Not covered
Spinal manipulations (20 visits per year ¹)	\$0, after deductible	50%, after deductible
Physical/occupational therapy (20 visits per year ¹)		

Hospital/other medical services

Inpatient hospital services/days	\$0, after deductible/ unlimited days	50%, after deductible/ 70 days
Maternity hospitalization	Not covered	Not covered
Emergency room (not waived if admitted)	\$0, after deductible	\$0, after in-network deductible
Outpatient surgery	\$0, after deductible	50%, after deductible
Ambulance		
Outpatient lab/pathology		
Routine radiology/diagnostic		
MRI/MRA, CT/CTA scan, PET scan		
Biotech/specialty injectables		
Durable medical equipment (each year you have coverage up to \$2,000, which includes up to \$1,000 for diabetic equipment and supplies)		
Mental health/substance abuse/serious mental illness treatment		

Continued

Prescription drug

Benefits per calendar year	You pay in-network	You pay out-of-network*
Prescription deductible, individual/family	Integrated with medical	Integrated with medical
Generic formulary copay	\$0, after deductible	50%, after deductible
Brand formulary copay		
Non-formulary copay		
Prescription mail order	Available	Available
Maximum prescription drug benefit ¹ , individual/family	None	None

¹ Combined in and out of network

What's not covered?

- services not medically necessary;
- any treatment of substance abuse or mental illness, including serious mental illness;
- services or supplies that are experimental or investigative, except routine costs associated with qualifying 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;
- alternative therapies, such as acupuncture;
- dental care, including dental implants or dentures, and nonsurgical treatment of temporomandibular joint syndrome (TMJ);
- treatment of obesity, except for surgical treatment of morbid obesity when medically necessary;
- routine foot care, except for medically necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease including, but not limited to, diabetes;
- foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
- routine physical exams for nonpreventive purposes, such as insurance or employment applications, college, or premarital examinations;
- contraceptive devices;
- maternity;
- routine eye care;
- immunizations for travel or employment;
- services or supplies payable under workers' compensation, motor vehicle insurance, or other legislation of similar purpose;
- cosmetic services/supplies;
- private duty nursing;
- self-injectable drugs except as specified under the prescription drug benefits;
- Charges related to any medical condition or illness for which medical advice or treatment was recommended or received in the 12 months preceding the effective date of your plan policy are excluded for the first 12 months. If you have been continuously insured for the past 12 months by a participating Blue Cross or Blue Shield plan, or the past 18 months by another plan, you may be able to receive credit for all or part of the 12-month exclusion.

Note: Eligible unmarried dependent children are generally covered to age 19 or age 23 (if full-time students). See contract for additional details.

This summary represents only a partial listing of benefits and exclusions of the Personal Choice program. Benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all your health care expenses. Read your contract/member handbook carefully to determine which health care services are covered.

If you need more information, please call 1-800-263-1410.

*It is important to note that all percentages are percentages of the plan allowance, not the provider's actual charge. 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. Claims payments for out-of-network professional providers (physicians) are based on Independence Blue Cross's (IBC's) own fee schedule. For services rendered by hospitals and other facility providers, the allowance may not refer to the actual amount paid by Personal Choice to the provider. Under IBC contracts with providers, hospitals, and other facility providers, IBC pays using bulk purchasing arrangements that save money at the end of the year but do not produce a uniform discount for each individual claim. Therefore, the amount paid by IBC at the time of any given claim may be more or it may be less than the amount used to calculate your liability.

