Temple University-$20

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 care through Personal Choices 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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>BENEFIT PERIOD</td>
<td>Calendar Year*</td>
<td>Calendar Year*</td>
</tr>
<tr>
<td>DEDUCTIBLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$0</td>
<td>$100**</td>
</tr>
<tr>
<td>Family</td>
<td>$0</td>
<td>$300**</td>
</tr>
<tr>
<td>AFTER DEDUCTIBLE, PLAN PAYS</td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>LIFETIME MAXIMUM</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>DOCTOR’S OFFICE VISITS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Services</td>
<td>$20 copayment</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>$20 copayment</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>COINSURANCE LIMIT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Includes coinsurance only)</td>
<td>Individual</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>$1,000</td>
</tr>
<tr>
<td>OUT-OF-POCKET MAXIMUM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(includes deductible, coinsurance and copayment)</td>
<td>Individual</td>
<td>$4,200</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>$12,600</td>
</tr>
<tr>
<td>PREVENTIVE CARE FOR ADULTS AND CHILDREN</td>
<td>100%</td>
<td>80%, NO deductible</td>
</tr>
<tr>
<td>PEDIATRIC IMMUNIZATIONS</td>
<td>100%</td>
<td>80%, NO deductible</td>
</tr>
</tbody>
</table>

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 Out-of-Network deductible does not apply to inpatient and outpatient facility charges.

* 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.

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
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ROUTINE GYNECOLOGICAL EXAM/PAP</strong></td>
<td>100%</td>
<td>80%, NO deductible</td>
</tr>
<tr>
<td>1 per year for women of any age†</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MAMMOGRAM</strong></td>
<td>100%</td>
<td>80%, NO deductible</td>
</tr>
<tr>
<td><strong>NUTRITION COUNSELING FOR WEIGHT MANAGEMENT</strong></td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>6 visits per year†</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ALLERGY INJECTIONS</strong></td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>(Office visit copayment waived if no office visit is charged)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MATERNITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First OB visit</td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>Hospital</td>
<td>100% after $100 copayment per day, maximum 3 days</td>
<td>100% after $100 copayment per day, maximum 3 days, inpatient/outpatient hospital facility charges, 80%, for other charges**</td>
</tr>
<tr>
<td><strong>INPATIENT HOSPITAL SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>100% after $100 copayment per day, maximum 3 days</td>
<td>100% after $100 copayment per day, maximum 3 days, inpatient/outpatient hospital facility charges, 80%, for other charges**</td>
</tr>
<tr>
<td>Physician/Surgeon</td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td><strong>INPATIENT HOSPITAL DAYS</strong></td>
<td>365</td>
<td>120†</td>
</tr>
<tr>
<td><strong>OUTPATIENT SURGERY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>100%</td>
<td>100%, inpatient/outpatient hospital facility charges, 80%, for other charges**</td>
</tr>
<tr>
<td>Physician/Surgeon</td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td><strong>EMERGENCY ROOM</strong></td>
<td>$100 copayment (copayment waived if admitted)</td>
<td>$100 copayment, no deductible (copayment waived if admitted)</td>
</tr>
<tr>
<td><strong>URGENT CARE CENTER</strong></td>
<td>$50 copayment</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td><strong>AMBULANCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency</td>
<td>100%</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>Non-emergency</td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td><strong>OUTPATIENT LABORATORY/PATHOLOGY</strong></td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td><strong>OUTPATIENT X-RAY/ RADIOLOGY</strong></td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td><strong>THERAPY SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, Speech and Occupational</td>
<td>$25 copayment</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>$25 copayment</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>36 visits per year†</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary Rehabilitation</td>
<td>$25 copayment</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>12 visits per year†</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthoptic/Pleoptic</td>
<td>$25 copayment</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>8 sessions lifetime maximum§</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE</strong></td>
<td>$25 copayment</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td><strong>CHEMO/RADIATION/DIALYSIS</strong></td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td><strong>OUTPATIENT PRIVATE DUTY NURSING</strong></td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
</tbody>
</table>

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

** Out-of-Network deductible does not apply to inpatient and outpatient facility charges.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>SKILLED NURSING FACILITY</td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>HOSPICE AND HOME HEALTH CARE</td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>DURABLE MEDICAL EQUIPMENT AND PROSTHETICS</td>
<td>100%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>OUTPATIENT DIABETIC EDUCATION</td>
<td>100%</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**MENTAL HEALTH CARE**

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>$20 copayment</td>
<td>80%, after deductible</td>
</tr>
</tbody>
</table>
| Inpatient        | 100% after $100 copayment per day, maximum 3 days | 100% after $100 copayment per day, maximum 3 days, inpatient/outpatient hospital facility charges,** 80%, for other charges**

**SERIOUS MENTAL ILLNESS CARE**

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>$20 copayment</td>
<td>80%, after deductible</td>
</tr>
</tbody>
</table>
| Inpatient        | 100% after $100 copayment per day, maximum 3 days | 100% after $100 copayment per day, maximum 3 days, inpatient/outpatient hospital facility charges,** 80%, for other charges**

**SUBSTANCE ABUSE TREATMENT**

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient/Partial Facility Visits</td>
<td>$20 copayment</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>
| Rehabilitation                | 100% after $100 copayment per day, maximum 3 days | 100% after $100 copayment per day, maximum 3 days, inpatient/outpatient hospital facility charges,** 80%, for other charges**
| Detoxification                | 100% after $100 copayment per day, maximum 3 days | 100% after $100 copayment per day, maximum 3 days, inpatient/outpatient hospital facility charges,** 80%, for other charges**

---

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 Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, mental health, serious mental illness and substance abuse services

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

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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
- Charges in excess of benefit maximums or allowable charges as set forth in the group contract
- Services or supplies which 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

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. 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).
### Services That Require Preauthorization

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network (Personal Choice® network provider or BlueCard® PPO provider)</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALL NON-EMERGENCY INPATIENT ADMISSIONS</strong> (Except maternity admissions)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Hyperbaric Oxygen</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Pain management procedures (including epidural injections, transformamidal epidural injections, paravertebral facet joint injections)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>OUTPATIENT SURGICAL PROCEDURES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bunionectomy</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Cataract Surgery</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Cochlear implant surgery</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Laparoscopic Cholecystectomy</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Hemorhoidectomy</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Hernia Repair</td>
<td>NOT Required</td>
<td>Required</td>
</tr>
<tr>
<td>Arthoscopic Knee Surgery/Diagnostic Arthroscopy</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Obesity Surgery</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Prostate Surgery</td>
<td>NOT Required</td>
<td>Required</td>
</tr>
<tr>
<td>Spinal/Vertebral Surgery</td>
<td>NOT Required</td>
<td>Required</td>
</tr>
<tr>
<td>Submucous Resection (nasal surgery)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Tonsillectomy and/or Adenoidecotomy</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>RECONSTRUCTIVE PROCEDURES AND POTENTIALLY COSMETIC PROCEDURES</strong> (for a complete list of these procedures, please see Benefits that Require preauthorization available on ibx.com)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Surgery for varicose veins, including perforators and sclerotherapy</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Orthognathic surgery procedures, including but not limited to, bone graft, genioplasty, osteoplasty, mentoplasty, osteotomies</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>TRANSPLANTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OPERATIVE AND DIAGNOSTIC ENDOSCOPIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI/MRA</td>
<td>NOT Required</td>
<td>Required</td>
</tr>
<tr>
<td>CT/CTA SCAN</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>PET SCAN</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>NUCLEAR CARDIAC STUDIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OUTPATIENT THERAPIES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>OUTPATIENT PRIVATE DUTY NURSING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER FACILITY SERVICES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing, Inpatient Hospice, Home Health, Birth Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MENTAL HEALTH CARE, SUBSTANCE ABUSE AND SERIOUS MENTAL ILLNESS TREATMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Outpatient and Partial Facility</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>DAY REHABILITATION PROGRAMS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DENTAL SERVICES AS A RESULT OF ACCIDENTAL INJURY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NON-EMERGENCY AMBULANCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DURABLE MEDICAL EQUIPMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase items (including repairs and replacements) over $500, and ALL rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>PROSTHETICS AND ORTHOTICS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase items (including repairs and replacements) over $500 (excluding ostomy supplies)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>INFUSION THERAPY IN A HOME SETTING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administered in an Outpatient Facility or in a Professional Provider’s Office (see list included in your open enrollment packet)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>INFUSION THERAPY DRUGS</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Personal Choice network providers will obtain preauthorization for you, if it is required for the service provided. You are not required to obtain preauthorization when you are treated in a Personal Choice network hospital or facility or by a Personal Choice network doctor. Members are not responsible for financial penalties because a Personal Choice network provider does not obtain prior approval.

If you use a provider who is a BlueCard®PPO network provider, or an out-of-network provider, you must obtain preauthorization if required for the service or supply being provided. You may be subject to financial penalties if you do not obtain preauthorization.

Call Independence Blue Cross at the preauthorization telephone number listed on the back of your identification card to initiate preauthorization.

You may be responsible for financial penalties if you do not preauthorize services when you use a BlueCard® PPO provider, or an out-of-network provider. There is a $1,000 penalty for failure to preauthorize inpatient services or treatment, and a 20% reduction in benefits for failure to preauthorize outpatient services or treatment.

Preauthorization is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the pre-authorization is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.