Personal Choice

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USW Local 286 H & W Fund

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

Benefit	In-Network	Out-of-Network[1]
BENEFIT PERIOD	Calendar Year*	Calendar Year*
DEDUCTIBLE		
Individual	$0	$250
Family	$0	$500
AFTER DEDUCTIBLE, PLAN PAYS	100%	80%
OUT-OF-POCKET MAXIMUM[4]		
Individual	$6,600	$7,600
Family	$13,200	$15,200
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	$5 Copayment	80%, after deductible
Specialist Services	$5 Copayment	80%, after deductible
Telemedicine	100%	Not Covered
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	80%, NO deductible
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply)	80%, NO deductible
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per year for women of any age*[2]	100%	80%, NO deductible
MAMMOGRAM	100%	80%, 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.

4 In-network out-of-pocket maximum includes deductible, copays 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.

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Benefit	In-Network	Out-of-Network[1]
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per year*[2]	100%	80%, after deductible
MATERNITY		
First OB visit	$5 Copayment	80%, after deductible
Hospital	100%	80%, after deductible[3]
INPATIENT HOSPITAL SERVICES		
Facility	100%	80%, after deductible[3]
Physician/Surgeon	100%	80%, after deductible
INPATIENT HOSPITAL DAYS	365	70[3]
OUTPATIENT SURGERY		
Facility	100%	80%, after deductible
Physician/Surgeon	100%	80%, after deductible
EMERGENCY ROOM	$50 Copayment (waived if admitted)	$50 Copayment (waived if admitted)
URGENT CARE CENTER	$35 Copayment	80%, after deductible
AMBULANCE		
Emergency	100%	100%
Non-emergency	100%, after deductible	80%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	80%, after deductible
OUTPATIENT X-RAY/RADIOLOGY	100%	80%, after deductible
THERAPY SERVICES		
Physical, Speech and Occupational	$10 Copayment	80%, after deductible
Cardiac Rehabilitation 36 visits per year[2]	$10 Copayment	80%, after deductible
Pulmonary Rehabilitation 12 visits per year[2]	$10 Copayment	80%, after deductible
Respiratory Therapy	$10 Copayment	80%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE	$10 Copayment	80%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	80%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	100%	80%, after deductible
SKILLED NURSING FACILITY	100%	80%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	80%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	100%	80%, after deductible
OUTPATIENT DIABETIC EDUCATION	100%	Not covered
MENTAL HEALTH CARE		
Outpatient	$5 Copayment	80%, after deductible
Inpatient	100%	80%, after deductible[3]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$5 Copayment	80%, after deductible
Inpatient	100%	80%, after deductible[3]

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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]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits	$5 Copayment	80%, after deductible
Rehabilitation	100%	80%, after deductible[3]
Detoxification	100%	80%, after deductible[3]

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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 (except as specified in a group contract)
- 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

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 1-800-626-8144 (outside Philadelphia) or 215-557-7577 (if calling within the Philadelphia area).

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.

Standard Prescription Drug Program

$5/$10

The Standard Drug Program is a comprehensive benefit that provides coverage for prescription drugs[1] when prescribed by a licensed, practicing physician. Generic drugs are just as effective as brand drugs. Ask your physician whether generic drugs are right for you.

Benefit	Coverage
Retail Pharmacy - Member Cost Sharing *(Participating Pharmacy)*	
Generic	$5 Copayment
Brand	$10 Copayment
Mail Order Pharmacy - Member Cost Sharing *(Participating Pharmacy) Available for maintenance drugs*	
Generic	$5 Copayment (1-30 days supply); $5 Copayment (31-90 days supply)
Brand	$10 Copayment (1-30 days supply); $10 Copayment (31-90 days supply)
Total Out-of-Pocket Maximum	Please refer to your Medical Coverage Benefits at a Glance for information about out-of-pocket maximum values. Out-of-pocket maximum includes applicable copayments, coinsurance and deductibles. Your out-of-pocket maximum is a combined maximum of medical, prescription drug and any included pediatric vision and pediatric dental benefits as defined by your benefit plan.
Out-of-Network Reimbursement	50% of drugs retail cost for the total amount dispensed. Member must submit for reimbursement.
Network	FutureScripts network* includes more than 60,000 retail pharmacies. You can locate a participating pharmacy near you on **www.ibx.com** by selecting the *Find a Participating Pharmacy* feature.
Dispensing Limits	
Retail	Up to 34 days supply
Mail order for maintenance drugs	Up to 90 days supply
Specialty Pharmacy Program *Mandatory for Self-Administered Specialty Drugs*	All covered self-administered specialty medications except insulin will be provided through the convenient Specialty Pharmacy Program for the appropriate cost sharing indicated above. Benefits are available for up to a thirty (30) days supply.

FutureScripts is an independent company providing pharmacy benefit management service

Benefit	Coverage
Covered Prescription Drugs[1]	Compound medications of which at least one ingredient is a prescription drug
	Contraceptives
	Prescribed smoking cessation drugs
	Self-injectable drugs
	Retin-A through age 35
	Insulin
	Insulin needles and syringes
	Lancets (no copayment required at participating pharmacies)
	Glucometers (no copayment required at participating pharmacies)
	Diabetic supplies (i.e., test strips)

1 This summary is intended to highlight the benefits available to you. For a complete program description, including all benefits, limitations, and exclusions, refer to your benefit booklet or group contract.

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What is Not Covered?

- Injectable fertility drugs
- Non Federal Legend Drugs
- Weight control drugs
- Immunization agents, biologicals, allergy serums, blood, or blood plasma
- Drugs used for cosmetic purposes (e.g., anabolic steroids and minoxidil lotion, Retin-A for aging skin)
- Devices or supplies except those specifically listed under covered drugs
- Drugs labeled 'Caution-limited by Federal Law to investigational use', even though a charge is made to an individual
- Experimental drugs
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Drugs and supplies that can be purchased over the counter except those covered per mandate (with a doctor's prescription)