Independence

Temple University Health System

	Personal Choice Temple Care PHO			Personal Choice Advantage Plan PHO			Personal Choice High Option 10	
	Temple Care Network	Personal Choice Network	Out-of-Network***	Temple Care Network	Personal Choice Network	Out-of-Network***	In Network	Out-of-Network***
BENEFIT PERIOD	Calendar Year*	Calendar Year*	Calendar Year*	Calendar Year*	Calendar Year*	Calendar Year*	Calendar year*	Calendar year*
DEDUCTIBLE								
Individual	None	$500	$1,000	None	$250	$500	$0	$500
Family	None	$1,500	$3,000	None	$750	$1,500	$0	$1,500
COINSURANCE	100%	80%, after deductible	60%, after deductible	100%	90%, after deductible	70%, after deductible	100%	80%, after deductible
COINSURANCE MAXIMUM								
Individual	None	$3,000	$4,000	None	$2,000	$3,000	None	$1,000
Family	None	$9,000	$12,000	None	$6,000	$9,000	None	$3,000
OUT-OF-POCKET MAXIMUM[3]								
Individual	$1,000	$4,200	None	$1,000	$3,750	None	$1,000	Not Applicable
Family	$3,000	$10,700	None	$3,000	$10,700	None	$3,000	Not Applicable
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS								
Primary care services	$5 copayment	$20 copayment	60%, after deductible	$15 copayment	$20 copayment	70%, after deductible	$10 copayment	80%, after deductible
Specialist services	$5 copayment	$20 copayment	60%, after deductible	$15 copayment	$20 copayment	70%, after deductible	$10 copayment	80%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	100%	60%, no deductible	100%	100%	70%, no deductible	100%	80%, no deductible
PEDIATRIC IMMUNIZATIONS	100%	100%	60%, no deductible	100%	100%	70%, no deductible	100%	80%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP	100%	100%	60%, no deductible	100%	100%	70%, no deductible	100%	80%, no deductible
MAMMOGRAM	100%	100%	60%, no deductible	100%	100%	70%, no deductible	100%	80%, no deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	100%	60%, after deductible	100%	100%	70%, after deductible	100%	80%, after deductible
OUTPATIENT X-RAY/RADIOLOGY								
Routine radiology/diagnostic	100%	100%	60%, after deductible	100%	100%	70%, after deductible	100%	80%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	100%	100%	60%, after deductible	100%	100%	70%, after deductible	100%	80%, after deductible
MATERNITY								
First OB visit	$5 copayment	$20 copayment	60%, after deductible	$15 copayment	$20 copayment	70%, after deductible	$10 copayment	80%, after deductible
Obstetrical/maternity care	100%	80%, after deductible	60%, after deductible	100%	90%, after deductible	70%, after deductible	100%	80%, after deductible
Hospital	100%	$2,000 copayment per admission, 80% after deductible (including emergency admissions)	60%, after deductible (including emergency admissions)	100%	$250 copayment per admission, 90% after deductible (including emergency admissions)	70%, after deductible, (including emergency admissions)	100%	80%, after deductible
INPATIENT HOSPITAL SERVICES	100%	$2,000 copayment per admission, 80% after deductible (including emergency admissions)	60%, after deductible (including emergency admissions)	100%	$250 copayment per admission, 90% after deductible (including emergency admissions)	70%, after deductible, (including emergency admissions)	100%	80%, after deductible
INPATIENT HOSPITAL DAYS	365	365	70	365	365	70	365	70
INPATIENT CONSULTATIONS	100%	80%, after deductible	60%, after deductible	100%	90%, after deductible	70%, after deductible	100%	80%, after deductible
EMERGENCY ROOM	$75 copayment (copayment waived if admitted)	$75 copayment (copayment waived if admitted)	$75 copayment (copayment waived if admitted)	$75 copayment (copayment waived if admitted)	$75 copayment (copayment waived if admitted)	$75 copayment (copayment waived if admitted)	$75 copayment (copayment waived if admitted)	$75 copayment, no deductible (copayment waived if admitted)
URGENT CARE CENTER	$52 Copayment	$52 Copayment	60%, after deductible	$52 copayment	$52 copayment	70%, after deductible	$52 Copayment	80%, after deductible
RETAIL CLINIC	$5 Copayment	$20 Copayment	60%, after deductible	$15 Copayment	$20 Copayment	70%, after deductible	$10 Copayment	80%, after deductible
OUTPATIENT SURGERY	100%	$400 copayment, 80% after deductible	60%, after deductible	100%	$100 copayment, 90% after deductible	70%, after deductible	100%	80%, after deductible
ASSISTANT SURGEON	100%	80%, after deductible	60%, after deductible	100%	90%, after deductible	70%, after deductible	100%	80%, after deductible
ANESTHESIA	100%	80%, after deductible	60%, after deductible	100%	90%, after deductible	70%, after deductible	100%	80%, after deductible
AMBULANCE								
Emergency	100%	100%, no deductible	100%, no deductible	100%	100%, no deductible	100%, no deductible	100%	80%, after deductible
Non-Emergency	100%	80%, after deductible	60%, after deductible	100%	90%, after deductible	70%, after deductible	100%	80%, after deductible

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Physical, speech, occupational therapy (60 visits per benefit period)**	$5 copayment	$20 copayment	60%, after deductible	$15 copayment	$20 copayment	70%, after deductible	$15 copayment	80%, after deductible
Cardiac rehabilitation therapy (36 visits per benefit period)**	$5 copayment	$20 copayment	60%, after deductible	$15 copayment	$20 copayment	70%, after deductible	$15 copayment	80%, after deductible
Respiratory therapy	$5 copayment	$20 copayment	60%, after deductible	$15 copayment	$20 copayment	70%, after deductible	$15 copayment	80%, after deductible
Orthoptic/pleoptic (8 sessions per lifetime)	Not Available	$20 copayment	60%, after deductible	Not Available	$20 copayment	70%, after deductible	$15 copayment**	80%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE (30 visits per benefit period)	Not Available	$20 copayment	60%, after deductible	Not Available	$20 copayment	70%, after deductible	$15 copayment	80%, after deductible
CHEMO / RADIATION / DIALYSIS	100%	80%, after deductible	60%, after deductible	100%	90%, after deductible	70%, after deductible	100%	80%, after deductible
OUTPATIENT PRIVATE DUTY NURSING (360 hours per benefit period)	Not Available	80%, after deductible	60%, after deductible	Not Available	90%, after deductible	70%, after deductible	100%	80%, after deductible
SKILLED NURSING FACILITY (120 days per benefit period)	Not Available	80%, after deductible	60%, after deductible	Not Available	90%, after deductible	70%, after deductible	100%	80%, after deductible
OUTPATIENT MENTAL HEALTH	100%	100%	60%, after deductible	100%	100%	70%, after deductible	100%	80%, after deductible
INPATIENT MENTAL HEALTH	100%	$2,000 copayment per admission, 80% after deductible (including emergency admissions)	60%, after deductible	100%	$250 copayment per admission, 90% after deductible (including emergency admissions)	70%, after deductible	100%	80%, after deductible
OUTPATIENT SERIOUS MENTAL ILLNESS	100%	100%	60%, after deductible	100%	100%	70%, after deductible	100%	80%, after deductible
INPATIENT SERIOUS MENTAL HEALTH	100%	$2,000 copayment per admission, 80% after deductible (including emergency admissions)	60%, after deductible	100%	$250 copayment per admission, 90% after deductible (including emergency admissions)	70%, after deductible	100%	80%, after deductible
SUBSTANCE ABUSE TREATMENT Outpatient/partial facility visits	Not Available	100%	60%, after deductible	Not Available	100%	70%, after deductible	100%	80%, after deductible
Rehabilitation	100%****	$2,000 copayment per admission, 80% after deductible (including emergency admissions)	60%, after deductible	100%****	$250 copayment per admission, 90% after deductible (including emergency admissions)	70%, after deductible	100%	80%, after deductible
Detoxification	Not Available	$2,000 copayment per admission, 80% after deductible (including emergency admissions)	60%, after deductible	Not Available	$250 copayment per admission, 90% after deductible (including emergency admissions)	70%, after deductible	100%	80%, after deductible
HOSPICE	Not Available	80%, after deductible	60%, after deductible	Not Available	90%, after deductible	70%, after deductible	100%	80%, after deductible
HOME HEALTH CARE	Not Available	80%, after deductible	60%, after deductible	Not Available	90%, after deductible	70%, after deductible	100%	80%, after deductible
INFUSION THERAPY	Not Available	80%, after deductible	60%. after deductible	Not Available	90%, after deductible	70%. after deductible	100%	80%, after deductible
DURABLE MEDICAL EQUIPMENT	Not Available	80%, after deductible	60%, after deductible	Not Available	90%, after deductible	70%, after deductible	100%	80%, after deductible
PROSTHETICS	Not Available	80%, after deductible	60%, after deductible	Not Available	90%, after deductible	70%, after deductible	100%	80%, after deductible
OUTPATIENT DIABETIC EDUCATION	100%	80%, after deductible	Not Covered	100%	90%, after deductible	Not Covered	100%	Not Covered
MEDICAL FOODS AND NUTRITION FORMULAS	Not Available	80%, after deductible	60%, after deductible	Not Available	90%, after deductible	70%, after deductible	100%	80%, after deductible
BLOOD	100%	80%, after deductible	60%, after deductible	100%	90%, after deductible	70%, after deductible	100%	80%, after deductible

* A calendar year benefit period is a consecutive 12-month period that begins on your employer's effective date of January 1, 2015.

** Combined in/out-of-network.

*** Out-of-network, nonparticipating 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 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 Independence Blue Cross (IBC) contracts with 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. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the provider's actua charge.

**** Basic services available through Temple

1 Office visit subject to copayment.

2 Out-of-network deductible does not apply to inpatient and outpatient hospital facility charges.

3 In-network out-of-pocket maximum includes deductible, copays and coinsurance.

These summaries represent only a partial listing of benefits and exclusions of the Personal Choice program described in these summaries. If you need more information, please call Accolade Member Services at 1-888-659-8302.